Termination of Domestic Partnership

I, _____, [*employee name*] submit this Affidavit of Termination of Domestic Partnership to cancel the Domestic Partner Affidavit previously filed. I declare and acknowledge that I wish to cancel the Domestic Partner Affidavit for this reason:

☐ My Domestic Partnership with _____ [*name*] ended on _____ [*date*].

☐ My Domestic Partner, _____ [*name*], died on _____ [*date*].

I understand that the effect of filing this Affidavit of Termination of Domestic Partnership is that my Domestic Partner's eligibility for coverage under ARS's benefits program will end. Coverage will terminate on the last day of the month in which the partnership ended or this form was filed, whichever is later, in accordance with the plan documents. I further understand that my former domestic partner is not eligible for COBRA continuation coverage.

I also understand that another Affidavit of Domestic Partnership cannot be filed until the earlier of:

☐ Six (6) months from the date the Termination of Domestic Partnership was filed, or

☐ The date I register a domestic partner or enter into a civil union in a state or municipality where such registration exists.

I certify that I have mailed or will mail within 30 days my former Domestic Partner a completed and signed copy of this Affidavit to him/her at the following address (which is his/her most current address known to me), unless my Domestic Partner's death is the reason for termination of this relationship:

_____

_____

I affirm that the assertions in this Affidavit are true and correct to the best of my knowledge.

_____ _____

Employee Signature Date